

Pakistan's Lady Health Worker Labor Movement and the Moral Economy of Heroism

Svea Closser

Abstract

In December 2012, militants began targeted attacks on workers going door-to-door in Pakistan delivering polio vaccine, including members of a CHW cadre called Lady Health Workers. In the next several years, more than 50 workers, most of them women, were murdered as they worked. Media accounts frequently refer to these workers as “aid workers” or “heroes.” This paper complicates and theorizes this conception.

Two conflicting moral economies around the work of Lady Health Workers existed before the targeted killings began; both have amplified since. One, shared among the LHWs themselves, centers around ideas of community health work as deserving of remuneration just like other government work. The other, promoted by the Global Polio Eradication Initiative at the international level, conceptualizes ground level workers like LHWs as “heroes,” not as labor—eclipsing the LHWs’ own discourse in the international sphere.

*This paper appeared on pp. 16-28 of a special issue of the journal *Annals of Anthropological Practice*, “Community Health Workers and Social Change: Local and Global Perspectives,” Volume 39 Issue 1:

<http://onlinelibrary.wiley.com/doi/10.1111/napa.2015.39.issue-1/issuetoc>

The old, central areas of urban Hyderabad in Sindh, Pakistan are a maze of small alleyways, some barely wide enough for a vehicle, some only passable on foot. In a clearing in the midst of these alleyways is a cluster of buildings: the government health post where Noreen¹ works. Its manicured lawns, marble-tiled barrier walls, and recently painted mauve exterior stand in contrast to the surrounding area, where hasty new construction coexists with crumbling old buildings under a tangle of telephone wires and storefront signs.

I meet with Noreen in a room cleared for our purposes. The room is freshly painted, though the job was a bit sloppy—flecks of paint mark the windows and the marble-tiled floor. There are a few caned chairs in the room, and a freezer with UNICEF stickers on it. The freezer is a little unsteady and has been shimmed up with concrete pieces and folded bits of paper.

Noreen is a Lady Health Worker, a type of Community Health Worker—the lowest rung of Pakistan’s health hierarchy. I’ve been told about Noreen already, by one of the doctors at the health post: “Noreen is exceptional; she works so hard,” the doctor had said.

Noreen greets me warmly, her pink-and-gold shawl tossed casually over her thin shoulders. She’s about 30 years old. She smiles widely and laughs easily, but her overall manner is careful and serious. I ask her about her family and her work.

My family is big—it’s a joint family. I have three brothers and six sisters. My father died a year—a year and a half ago. My oldest brother works as a shopkeeper. He makes eight or ten thousand rupees [about \$110 a month]. But he has his own two kids, he has his own wife, they need money.

The brother who helps me with my work, he has three kids. His right leg was paralyzed by polio when he was a child. He doesn’t have any work. I mean, he sells toys, stuff for kids, on the street. But he doesn’t earn anything. Nothing.

I’m trying, I need to get my younger sisters married. When there’s no father, there’s nothing [to use for a dowry]. I’m still at home, unmarried. Because I’m the only one that works, since I was twelve, I’ve been working. The way things are getting expensive [her voice shakes], I have to work.

I had such desire to become a doctor! There was a dentist here, and I used to go to her office and follow her around and work for her, just out of interest, I wanted to know more about how I could become a doctor. She told me to apply to be an

¹ Names of respondents—and of small cities and towns—have been changed.

LHW.... I told her, 'no, my studies will suffer,' but she convinced me to do it... And anyway, I couldn't really study any more. My father didn't have any money. So I did a B.A. while I was an LHW [using her salary to cover the fees], but then I had to leave it there. I really wasn't able to study with so many polio rounds. At the beginning, there wasn't that much work for polio... But in the last few years it's become much more strict... and three years ago they made me an Area in Charge [low level supervisor]. And polio took that much more time. I've been thinking of further study, because really, I want to move up. But I look, and there really aren't any ways for me to advance. There's no chance, absolutely no way. All of my dreams, I've left them all behind. What I wanted to do.

My older brother, who works in the store, he understands all my problems. Because he, you know, he works just like me. He knows what it is to get yelled at by your supervisors.

I mean, I'm not saying I do a perfect job. I try my best, but I have faults. But I do, I do as well as I can. But my supervisors, I don't understand what they think of me [patta nahin in log mujhe kya samajhte hain]. It's really, it's wrong. The way they look at me and what I do. They will say anything to me.

A human deserves respect, whether they're male or female. But I don't feel any such respect here. Look, I just try to get my work done. I just make sure nobody has a chance to come down hard on me for any mistakes.

Seven thousand rupees [less than \$100 a month], nobody can really survive on that. But you know, just now, you saw that woman come through, she's delivering her baby here. I gave her the referral to come here. I told her, there are doctors there that will take care of you. Now, she'll respect me, right? I didn't take anything from her. OK, yeah, if I was a doctor I could really help her. But still, this is good work. I'm not taking anything from people. I'm giving them something.

Lady Health Workers: A Targeted Community Health Worker Force

In December 2012, a year and a half after I spoke with Noreen, militants began targeted attacks on workers going door-to-door in Pakistan delivering polio vaccine, including Lady Health Workers (LHWs). More than 50 workers, most of them women, were murdered as they worked in the next several years. These attacks were particularly shocking because there was little precedent for violence toward vaccination workers,

even in Pakistan's many conflict zones. Several factors likely led to this outcome: the CIA's use of a fake vaccination campaign in its search for Osama bin Laden; the high political profile of polio eradication; and the international shock value of attacking health workers (Closser and Jooma 2013; Abimbola, Malik, and Mansoor 2013).

Media accounts frequently refer to these workers as "aid workers" or "heroes" (Polio Vaccination Workers Shot Dead in Pakistan 2012; Walsh and McNeil 2012; Khazan 2012; Chatterjee 2012). My goal in this paper is to complicate and theorize this conception. In the process, I will discuss the importance of Community Health Worker (CHW) labor movements and show how the voices of CHWs can be silenced by the moral economy of global health.

Two conflicting moral economies around the work of Lady Health Workers existed before the targeted killings began; both have amplified since. One, shared among the LHWs themselves, centers around ideas of community health work as deserving of remuneration just like other government work. The other, promoted by the Global Polio Eradication Initiative at the international level, eclipses the LHWs' own discourse in the international sphere. This international moral economy conceptualizes ground level workers like LHWs as "heroes," not as labor.

Methods

In June of 2011, I conducted semistructured interviews with 13 Lady Health Workers, 7 Lady Health Supervisors (LHWs who were promoted to a supervisory role), and 5 male district-level supervisors in the provinces of Sindh and Punjab in Pakistan. This research was funded by UNICEF, who was interested in the motivations of polio eradication's ground-level staff. The research was approved by the Middlebury College IRB.

As I was consulting for UNICEF, I was thus subject to their security restrictions, which meant riding around in their giant white Land Cruisers at all times, and sometimes—in the Punjab—also being accompanied by another vehicle full of Special Forces police officers. I was thus whisked around cities like Multan by an escort vehicle bristling with machine guns, and my arrival at health posts was marked as that of a VIP (usually such escorts are reserved for high-level government officials). This had the effect of intimidating some interviewees. Other interviewees had a very positive response: they were glad, they said, that someone who seemed to have some clout was listening to them.

Other research projects I have been involved in included interviews with over 50 LHWs as well as with international polio eradication policymakers (Closser 2010; Closser et al.

2014). These other research projects were more ethnographic, including not just interviews but extensive participant observation. In 2007-2008, I conducted participant observation in LHW work in a variety of settings in Pakistan, as well as in lower-middle-class families where some women were LHWs. While it is not my focus in this article, this work informs my thinking deeply. Long-term engagement in participant observation is important for understanding how CHW work is embedded in local moral economies. This sort of contextual understanding would have been difficult to obtain from behind the bulletproof windows of a Land Cruiser.

Lady Health Workers and Polio Campaigns

Pakistan's Lady Health Worker program, founded in 1994, initially aimed to provide community-based maternal and child health services to rural populations. LHWs have at least an eighth grade education, and receive a few months of health-specific training. Over the past twenty years, both the numbers of Lady Health Workers and the responsibilities they shoulder have increased substantially; there are now over 100,000 LHWs providing a variety of health services to their neighbors, from family planning education to making sure TB patients take their drugs on time. The program has consistently been cited as a model for how to implement Community Health Worker programs "at scale" (Haines et al. 2007; GHWA Task Force on Scaling Up Education and Training for Health Workers 2008).

The single activity that takes up the most of Lady Health Workers' time is door-to-door work for polio eradication campaigns. The Global Polio Eradication Initiative—a billion-dollar-a-year project globally—aims to completely rid the world of poliovirus by creating a firewall of vaccinated children. Pakistan, along with Afghanistan and Nigeria, is one of the last three countries that have been unable to eliminate the virus.² These three countries form what polio eradication's oversight board calls the "hard core" of polio transmission, and the \$1 billion a year budget is concentrated here (Independent Monitoring Board of the Global Polio Eradication Initiative 2013). It's estimated that expenditures for polio eradication in Pakistan alone will be nearly \$700 million over the next five years (World Health Organization 2014).

The lion's share of this money in Pakistan is spent on delivering polio vaccine door-to-door. Oral polio vaccine is delivered to every child in Pakistan under five multiple times a year. In areas like Karachi, where polio transmission is ongoing, there are as many as eleven campaigns a year, in the hopes that increasing the intensity of vaccination will lead to a critical mass of immune children and an end to polio transmission. With huge

² Ongoing outbreaks in other parts of the globe are seeded by poliovirus in these countries.

requirements in terms of vaccine, logistics, and supervision, these campaigns are expensive.

Most women who work on polio immunization campaigns fall into one of two major groups (both types were targeted by the killers). Some are “volunteers,” or day wage laborers hired solely for polio work. Nearly half of the workforce, however—and those consistently described by superiors and policymakers at all levels as being more reliable—are Lady Health Workers.

When this research was carried out in summer 2011, LHWs received a salary top-up of Rs. 150 per day, at the time around \$2, for polio work. Since the interviews excerpted here, pay has been raised for polio work to Rs. 250—with inflation an increase of just 50 cents per day.³ While meaningful symbolically, this raise does not significantly change workers’ financial situation in real terms.

The Moral Economy of Lady Health Workers

In his work on the poor in eighteenth century England, E. P. Thompson defined moral economy as “a consistent traditional view of social norms and obligations, of the proper economic functions of several parties within the community” (Thompson 1971:79). In this section of the paper, I use the term ‘moral economy’ in a way nearly identical to Thompson’s conception. James C. Scott, building on this definition, defined moral economy in peasant societies as “their notion of economic justice and their working definition of exploitation—their views of which claims on their product were tolerable and which intolerable” (Scott 1977:3).

In interviews, Lady Health Workers and their low-level supervisors laid out a consistent moral economy regarding their work. They spoke particularly passionately about pay; about relationships with supervisors; about the need to care for their own children; and about opportunities for advancement.

Pay and Benefits

Lady Health Workers articulated a shared moral economy around pay and benefits: that their remuneration should be comparable to other work requiring the ability to read and write, and that they should receive the same benefits as other Ministry of Health employees.

³ In some parts of the country, pay has been raised slightly more than this.

The pay that LHWs received for polio days was a source of particular dissatisfaction. Sentiments including "the pay is nothing" and "polio pay is much too low" were voiced in nearly every interview. Again and again, interviewees compared polio pay to rates of pay for unskilled labor (*mazdoori*). The going rates of pay for such unskilled labor ranged from two to four times the daily polio wage (pay for *mazdoor* was higher in major cities). LHWs reasoned that if unskilled laborers earned that much, polio workers--who were required to have some education and whose work was, as one supervisor put it, "sensitive"--should make more.

In the normal course of doing polio work, Lady Health Workers repeatedly pointed out, they incurred a number of expenses that were not reimbursed, making their take-home pay even lower. LHWs in Karachi described working in heat of 45 degrees Celsius (113 degrees Fahrenheit) and agonizing over whether to spend Rs. 20 [30 cents] on a bottle of cold water.

Low-level supervisors were also vocal about the rate of pay for workers. One asked, "How do you expect to have workers that look presentable, with nice clothes, when they're being paid 150 rupees a day?" Another asked how workers could be expected to work hard when "they could get four or five hundred rupees a day working in the vegetable market--and a watermelon to boot!"

Lady Health Workers were also upset that they did not receive the benefits—like retirement pensions—that others employed by the Ministry of Health enjoyed. As the vast majority of "regular" (benefits-eligible) Ministry of Health employees—from provincial leaders down to local vaccinators—are men, in a sense this was a demand to be given the same benefits as the men employed by the government health system. But LHWs discussing their desire for benefits did not frame it this way. Instead, they noted simply that after devoting years of their life to their position, they deserved the same job security and benefits as all other Ministry of Health employees.

Relationships with Supervisors

Lady Health Workers' moral economy around supervision was also consistent: "good" supervisors were understanding, forgiving, recognized and rewarded good work, and provided their subordinates with small short-term loans and small food gifts out of their own pockets when they saw that their subordinates were in need. Nearly all LHWs said many supervisors did not behave this way. Like Noreen in the opening interview to this article, many described negative experiences with supervisors.

Many, too, reported that positive feedback was nonexistent. “Not so much as a certificate,” one said. One group of Lady Health Workers discussed this issue:

LHW 1: If you do a good job, you get more work.

LHW 2: Right, they say, 'here, you did that well, now do this too.'

LHW 3: Whoever works well, makes the standard amount. People who hardly work at all, they make the same amount.

Caring for Your Own Children

Lady Health Workers with children articulated a moral economy around the needs of their children: they felt the needs of their own children should come before the needs of the children of others. They described regular LHW duties, which took them two or three hours in the morning, as manageable. In contrast, they said that polio work—which required a full day away from home and children—interfered with responsibilities to their own children. One explained:

We have families too, I have small children, my daughter is three months old. So, we spend so much time caring for others' children that our own children get left behind. So we have problems. I'm away from the house from 8 to 4, my older children come home from school, who will give them food?

Another LHW with a nine-month-old said:

Milk is a problem. During polio days, I have no choice but to give her formula. When I'm at home, I feed her my own milk. But when I go out--now it's not so bad, she's old enough to eat Cerelac, or toast. Before, when she was only drinking my milk, my husband would bring her to me on his motorcycle as I was working. [Laughing] Then I would feed her milk, and after she was fed, he would take her away. It was hard, yes!

This discourse, though, consistently looped back into talk about pay. Nearly all said the challenges they faced in balancing their work at home with their work on polio campaigns would be manageable--*if* they were making more money on polio days. Then they could afford to pay someone to watch their children.

Supervisors, too, saw Lady Health Workers' responsibilities as mothers as paramount. One Lady Health Supervisor described a recent experience with a pregnant LHW working on a polio campaign:

It's true that she fell. She fainted. But I've been told so strictly that all LHWs have to work. Everyone should work. Not one should be missing. But there are problems that women have. So what happened with that woman was, that same month, she had pains, and we brought her in, and she gave birth. Very prematurely. And the child that was born, was born with complications. The baby still has a chest infection.

Here, the Lady Health Supervisor blames the poor health of the LHWs' child on her requirement to work on polio campaigns.

Opportunities for Advancement

Lady Health Workers argued that those LHWs who worked the hardest and performed the best should have opportunities for job advancement. But job advancement was usually impossible. Many LHWs talked about their desire for more education, but nearly all of them said that the limited income that had caused them to become an LHW in the first place meant that further education was unattainable. One explained:

There's no chance. Of course I want to. You need qualifications, study, and connections. I don't have anything. I have interest in learning, and I learn whatever I can...

Even those fortunate enough to have the educational level and connections to become Lady Health Supervisors found their advancement opportunities extremely limited. "That's it," one Lady Health Supervisor said. "You get this far and the brakes engage." And LHWs were aware of this glass ceiling. "All I could possibly be is an LHS," one LHW said. "After that, it's doctors, et cetera. And as much as I want to do that, I've accepted that that sort of post is impossible for me."

The LHW Strikes

Theorists of moral economies posit that when—as in the case of Lady Health Workers—the ideals of the moral economy are not carried out in practice, resistance is likely to result. Scott writes of moral economies, “the violation of these standards could be expected to provoke resentment and resistance—not only because needs were unmet, but because rights were violated” (Scott 1977:6).

Lady Health Workers do engage in ongoing acts of resistance, particularly during polio campaigns; they have developed complex maneuvers for streamlining and minimizing their work while avoiding the most punitive attacks of supervisors (Closser 2010). Some

refuse to work on polio campaigns, though this strategy cannot work indefinitely if they want to keep their LHW jobs. One LHW I interviewed was refusing to work on polio campaigns on the grounds that her children needed her at home during the day, but admitted she would have to start polio work again shortly or lose her job.

Beyond these ad hoc forms of resistance (Scott 1985), many LHWs participate in a formal labor movement. Strikes in public places across the country have closed train stations and blocked roads. This movement aims to convince the government to conform to the expectations of the moral economy (cf. Taksa 1991). The movement gained significant traction in 2010, when LHW agitation led to a Supreme Court decision that LHWs had to be paid the national minimum wage (Rs. 7,000, or about \$100, per month) for their regular, non-polio work. This amount was more than double their previous wage of just over Rs. 3,000.

Despite the Supreme Court ruling, however, LHWs' wages were not immediately raised, leading to more strikes. In the protests that followed, LHWs also highlighted lack of maternity leave and benefits (Moazzam 2011; Shamsi 2011; LHWs Stage Sit-in Protest 2011; Shoe-String Budget: Health Worker Fuel Compensation Cut in Half to 35 Litres 2011). An LHW in Karachi described her participation:

My salary was Rs. 3000, when I went for the strike. The ones in front of the press club... I participated in all of them. Because Justice Iftikhar Chaudhry, when our supervisors were in Islamabad, he passed the pay increase. He said, a *mazdoor* [unskilled laborer] makes Rs. 7,000; LHWs work hard too, they should earn Rs. 7,000 too. But the order wasn't followed. So I went to the strikes.

They were organized by a national committee; our supervisors are in contact with one another, and they organized the LHWs, told us where to show up... And we all have to help each other. This isn't one person's problem, it's everyone's problem...

One time, we spent all night at the press club. And all the LHWs in Karachi were there. It was so organized, there was water, refreshments, medical supplies... There were so many people. Thousands. The whole area was jammed. Small children, big children, people brought their whole families--and they spent the whole night. And it was in the winter. You have to stick together, everyone was working together... People came from so far away, if they could come from that far away, then why wouldn't I come?

And then our salary became Rs. 7,000. Sure, I was a little scared--I'd heard firing often happens in those situations... but looking at the women who were there breastfeeding their babies--if they could come, then so could I.

The LHWs I interviewed in the cities of Karachi and Muzaffargarh had participated in the strikes; those in other areas of the country had not. Noreen, quoted at the beginning of this paper, said:

This month, some LHWs held protests to get their jobs regularized. But I didn't participate. My point of view was, look, we just got our salary raised, maybe if we keep working hard, they'll make our jobs regular too... They just raised our salary, the Supreme Court doubled our salary, where we used to make 3,000, now we make 7,000. Anyway, possibly they'll raise it further, if we quietly work hard. So I'm not sure why they went on strike—anyway, people have their own thoughts, when they get together and talk to each other. Here, from this center, nobody went.

SC: So, you're satisfied with 7,000?

Noreen: Sort of, I'm a little satisfied.

Noreen's response points to the fact that the power to take collective action resides in social networks (cf. Moodie 1986). These networks were in place in some parts of the country but not in others. While Noreen was only "a little" satisfied with a 7,000 rupee wage, and felt that "regularization" of work, including pensions and benefits, was important, her outlets for achieving these goals were limited to hoping that quietly working hard would make them materialize. Without others around her participating in the movement—without the support and organization of Lady Health Supervisors as was the case in Karachi—Noreen did not participate in the strikes, and indeed described them as "misguided."

Whether or not they supported the strikes, there was near-universal support among LHWs—and among their district-level supervisors—for the Supreme Court decision. The moral economy described here was shared by high-level supervisors at the district level as well as Lady Health Supervisors and LHWs. As one district-level supervisor pointed out, in recent years LHW responsibilities had multiplied. He ticked responsibilities off on his fingers: tuberculosis treatment, vaccination education, polio campaigns, measles campaigns, anti-smoking initiatives, family planning, maternal/neonatal tetanus, floods.

"They haven't been paid in six months," he said, "but still when we call them and say, 'come to the stop smoking march,' or whatever it is this week, they have to get a rickshaw and show up."

Another supervisor added, "you can't get any more juice out of them, they've been squeezed."

As these supervisors noted, pay many months in arrears was the norm for LHWs in many parts of the country. In 2011 and 2012, strikes continued over the issues of late pay and the need to extend to LHWs the same benefits extended to other government employees (Khaliq 2012).

Immediately after murders of polio workers began, on December 23rd, 2012, LHWs, angry that they were required to continue working on polio campaigns when UN staff had been pulled from the field, staged a sit-in at the Prime Minister's house in Islamabad (Wasif 2012). Ultimately, in January 2013, the government agreed to "regularize" LHWs—that is, to extend to them the same job security and benefits as other government employees enjoy (Junaidi 2013). This was a major victory, but a year later, for many LHWs these promised benefits had not materialized (LHWs Strike a Deal with Govt, End Protest 2014).

Thus on a discursive level—by officially raising pay and by officially regularizing LHWs as government workers—the national government was forced to concede to the moral economy held by the LHWs. The Pakistani government was to some extent operating within the same moral economy as the LHWs, one which made high-level government authorities "in some measure the prisoners of the people" (Thompson 1971:79). That said, at the level of practice—actually delivering the promised pay and benefits—the national government alternately failed to follow through and lagged behind on its promises.

The Global Polio Eradication Initiative's Moral Economy

The Global Polio Eradication Initiative (GPEI) has its own powerful moral economy centering around the labor of Lady Health Workers, one entirely different from that of the LHWs themselves. This moral economy is centered around saving children from polio. Community Health Workers like LHWs are conceptualized as "heroes" exceptionally committed to children.

In thinking about the moral economy of a transnational aid project like the GPEI, I use Didier Fassin's expanded concept of moral economy—one that encompasses but goes beyond conceptions of economic justice. Fassin defines moral economies as "the production, distribution, circulation, and utilization of moral sentiments, emotions, and values, norms and obligations in the social space" (Fassin 2012:266). The sentiments,

emotions, and values surrounding Community Health Workers in general, and Lady Health Workers in particular, promoted by the GPEI are especially apparent in its literature aimed at donors.⁴

Children in GPEI's Moral Economy

The official discourse of the Global Polio Eradication Initiative—the language contained in its reports, newsletters, and funding updates—is to a large extent aimed at donors, and focused on convincing them that the project is worth supporting. The iconography and language of this official discourse follows the contours of the moral economy of childhood articulated by Didier Fassin very closely. Fassin describes a powerful moral economy where children are viewed as victims, as “sinless and powerless” (Fassin 2013:112). Fassin sums up this moral economy succinctly: “in contemporary public health, children come first (as goes the title of a UNICEF song)” (Fassin 2013:113).

The door-to-door vaccination campaigns carried out by the GPEI focus on children under 5, and in the iconography of the program, children are omnipresent. A few examples: A wide-eyed South Asian child receiving polio vaccine is the banner image on the GPEI's official website. The latest Strategic Plan's cover features a beaming child and a Community Health Worker. When Bill Gates—a major donor to the program—went to speak about polio eradication on the Daily Show, three children (one receiving polio vaccine) were projected on the screen behind him. And a TED talk by Bruce Aylward—the head of the GPEI at WHO—featured multiple photographs of a grinning child in tattered clothing accompanied by the following monologue:

Umar is seven years old, and he's from Northern Nigeria. He lives in a family home there with his eight brothers and sisters. Umar also has polio. Umar was paralyzed for life—his right leg was paralyzed in 2004. This leg—his right leg—now takes an awful beating, because he has to half crawl, because it's faster to move that way, to keep up with his friends, to keep up with his brothers and sisters, than to get up on his crutches and walk. But Umar is a fantastic student, he's an incredible kid. As—you probably can't see the detail here—but this is his report card, and you'll see, he's got perfect scores, he's got 100 percent in all the important things, like nursery rhymes, for example, there. But, you know, I'd love to be able to tell you that Umar is a typical kid with polio these days, but it's not true. Umar is an exceptional kid in exceptional circumstances. The reality of polio today is something very different. Polio strikes the poorest communities in the

⁴ Behind closed doors GPEI employees and officials frequently deviate widely from this official discourse, but this has little impact on the power of the public transcript (Scott 1990) that is my focus here.

world. It leaves their children paralyzed, and it drags their families deeper into poverty, because they're desperately searching, and they're desperately spending the little bit of savings that they have, trying in vain to find a cure for their children. We think children deserve better.

Community Health Workers in GPEI's Moral Economy

In this moral economy, centered on the goal of saving children from polio, Community Health Workers delivering vaccine are portrayed as selfless and extremely moral. Referred to as “volunteers”—even though everyone I spoke to at all levels of the program recognizes that they are not true volunteers—polio eradication's ground-level staff are presented to donors as inspirational models of commitment to children. The word “hero” is commonly used to describe them.

For example, in Polio News, a newsletter for donors and other interested parties, a monthly segment featured a “polio hero” every issue in late 2012 and into 2013. These “heroes” are portrayed as models of selfless dedication to the cause of saving children from polio. For example, Nana Kerima Ali, a polio hero in Niger, was featured in April 2013:

They travel by boat through crocodile-infested waters to reach the children of this small community. “I love children. I like to be around them. I do not want to see these children's future crippled because of polio,” says Nana, who has been a volunteer vaccinator since she was 15 years old.

In these narratives, poverty and difficult working conditions are framed as virtues. Mama Josephine, the “polio hero” from January 2013, lives in the DRC:

She can't afford transport or a babysitter, so she carries her baby boy with her on the 6 km journey to pick up the vaccine on foot, and then heads out into the community to ensure the children of Kalemby are protected against polio.

In this and other GPEI literature, polio eradication's ground level staff is consistently portrayed as selfless, undeterred by obstacles from lack of transport to crocodiles, and exceptionally committed to the cause of saving children.

The Reaction to the Worker Killings

The GPEI's response to the ongoing murders of frontline polio workers in Pakistan draws heavily on this conception of polio workers as people willing to go to any lengths to protect children from polio. Rather than being an unacceptable occupational hazard,

lethal targeting becomes just one more of the many obstacles these workers overcome in their quest to assist children.

While UN workers—many paid hundreds of dollars a day—were pulled from the field in 2013, LHWs were not. Instead, public statements about LHWs attested to their heroism. UNICEF and WHO released a statement saying, “Those killed or injured, many of whom are women, are among the hundreds of thousands of heroes who work selflessly to eradicate polio and provide other health services to children in Pakistan” (UNICEF and World Health Organization 2012).

The Polio News bulletins contained similar statements. The January 2013 issue read:

We dedicate the progress in polio eradication in 2012 to the health workers who made the ultimate sacrifice for a polio-free world. They are among the hundreds of thousands who work selflessly across Pakistan, Afghanistan, and Nigeria to eradicate polio... In their memory, we remain committed to making a polio-free world a reality.

And in February 2013, as targeted killings continued, Polio News said, “our thoughts are with the families of the brave souls who lost their lives while trying to create a better future for their nation’s children.”

In the moral economy of the GPEI, where saving children from polio is the greatest possible good, being killed while delivering polio vaccine is a tragedy that serves to further prove the deep morality of ground-level staff.

Moral Economies and Health Worker Rights

The LHWs’ moral economy has reach within Pakistan, and some limited resonance with the Pakistani government. But the international moral economy of CHWs has proved more powerful internationally, and its morals eclipse the demands of LHWs. If child survival and vaccination are the highest goods, and those who pursue those goals against all odds are “heroes,” then working conditions, pay, and benefits do not and cannot enter the picture. Questions of retirement pensions, maternity leave, and wages—central to the LHWs’ moral economy—are effectively eclipsed by the moral economy of heroism.

Reading over the official policy documents of the Global Polio Eradication Initiative—those not aimed at donors—one is struck by the lack of attention to the needs of LHWs—their core labor force, and one targeted with lethal violence. The international Independent Monitoring Board for polio eradication has given attention to the needs of

ground-level workers, consistently foregrounding the need for ground-level worker buy-in in its reports (e.g., Independent Monitoring Board of the Polio Eradication Initiative 2012). But internal documents from the national level in Pakistan and WHO in Geneva do not.

The most recent Technical Advisory Group report charting the way forward for Pakistan in 2014 mentions LHWs only once in its 19 pages—in a phrase stating that “increased use of lady health workers” will be important in a “further focus on efforts to improve performance” (WHO Regional Office for the Eastern Mediterranean 2014:11). And the Pakistani Government’s National Emergency Action Plan for polio eradication mentions LHWs only a few times in its 91 pages, always in the context of another goal: for example, “The LHW must be mindful of the OPV VVM and must not use the vaccine if it is in stage 3 or stage 4 despite the wastage of doses” (Government of Islamic Republic of Pakistan 2014:70). Far from LHWs’ needs being central in these documents, their satisfaction is not addressed at all, even instrumentally. Despite global discussions about the importance of Community Health Workers and ways of motivating them (Glenton et al. 2010; Nkonki, Cliff, and Sanders 2011; Rowe et al. 2005; McCoy et al. 2008; Franco et al. 2004), they quickly fall from view as part of a major initiative, even when they are being murdered in the process.

Rethinking Community Participation

The LHW strikes form a perhaps common but infrequently described and particularly under-theorized form of “participation” in health systems by community-level workers. The literature on CHW labor protests is thin to nonexistent—probably because striking community health workers violate the ideals of the international moral economy surrounding “good” CHWs. Heroes, after all, do not go on strike over maternity leave. They do their jobs no matter how horrible the working conditions.

Lynn Morgan points out that “when international health experts evaluate community participation, they tend to focus on whether or not communities are ‘cooperating’ with government-sponsored initiatives” (Morgan 1993:163)—and that strikes are rarely if ever seen as legitimate forms of participation. Yet the LHW labor movement and other CHW protest movements—which challenge the international moral economy of what CHW labor is supposed to entail—deserve attention as community participation in health.

The study of CHW strikes and other protest movements is an area in need of further ethnographic exploration. Little on the social organization or trajectory of such movements has been written, and questions of how these movements arise, and how and when they are successful, have immediate practical relevance.

As LHWs are quick to point out, their needs matter. They are not just providers of health care, but a population living on the edge, supporting their families in ways usually reserved for men, often because the men in their lives have failed to do so. When LHWs talk about health, they talk about the health of the neighbors they serve, but also about the health of their mothers, husbands, and children—endangered by the fact that LHWs themselves don't make quite enough to live on. Here, community members are demanding that good jobs, attention to the health of children, and true empowerment of women by providing them with the same work benefits as men be part of the global health agenda. Attention to such voices from ethnographers as well as health policy makers could help elevate this compelling moral economy to the world stage.

Abimbola, Seye, Asmat Ullah Malik, and Ghulam Farooq Mansoor

2013 The Final Push for Polio Eradication: Addressing the Challenge of Violence in Afghanistan, Pakistan, and Nigeria. *PLoS Med* 10(10): e1001529.

Chatterjee, Siddarth

2012 As Deaths Mount In Pakistan, Ending Polio Becomes An Act Of Courage. *Forbes*. <http://www.forbes.com/sites/realspin/2012/12/27/as-deaths-mount-in-pakistan-ending-polio-becomes-an-act-of-courage/>, accessed March 25, 2013.

Closser, Svea

2010 Chasing Polio in Pakistan: Why the World's Largest Public Health Initiative May Fail. Nashville: Vanderbilt University Press.

Closser, Svea, Kelly Cox, Thomas M. Parris, et al.

2014 The Impact of Polio Eradication on Routine Immunization and Primary Health Care: A Mixed-Methods Study. *Journal of Infectious Diseases* 210(suppl 1): S504–S513.

Closser, Svea, and Rashid Jooma

2013 Why We Must Provide Better Support for Pakistan's Female Frontline Health Workers. *PLoS Med* 10(10): e1001528.

Fassin, Didier

2012 Humanitarian Reason: A Moral History of the Present. University of California Press.

2013 Children as Victims: The Moral Economy of Childhood in the Times of AIDS. *In* When People Come First. Princeton, NJ: Princeton University Press.

Franco, Lynn M., Sara Bennett, Ruth Kanfer, and Patrick Stubblebine

2004 Determinants and Consequences of Health Worker Motivation in Hospitals in Jordan and Georgia. *Social Science & Medicine* 58(2): 343–355.

GHWA Task Force on Scaling Up Education, and and Training for Health Workers

2008 Pakistan's Lady Health Worker Programme. Geneva: World Health Organization.

Glenton, Claire, Inger B. Scheel, Sabina Pradhan, et al.

2010 The Female Community Health Volunteer Programme in Nepal: Decision Makers' Perceptions of Volunteerism, Payment and Other Incentives. *Social Science & Medicine* 70(12): 1920–1927.

Government of Islamic Republic of Pakistan
2014 National Emergency Action Plan 2014 For Polio Eradication. Islamabad:
Government of Pakistan.

Haines, Andy, David Sanders, Uta Lehmann, et al.
2007 Achieving Child Survival Goals: Potential Contribution of Community Health
Workers. *The Lancet* 369(9579): 2121–2131.

Independent Monitoring Board of the Global Polio Eradication Initiative
2013 Seventh Report. London.

Independent Monitoring Board of the Polio Eradication Initiative
2012 Ten Months and Counting. London: Independent Monitoring Board of the Global
Polio Eradication Initiative.

Junaidi, Ikram
2013 100,000 Lady Health Workers Get Their Service Regularised. *Dawn*, January 21.
<http://dawn.com/2013/01/21/100000-lady-health-workers-get-their-service-regularised/>,
accessed February 11, 2013.

Khaliq, Fazal
2012 Back Pay: Strikes Abound as Lady Health Workers Demand Salaries. *The
Express Tribune*, March 22. [http://tribune.com.pk/story/352706/back-pay-strikes-abound-
as-lady-health-workers-demand-salaries/](http://tribune.com.pk/story/352706/back-pay-strikes-abound-as-lady-health-workers-demand-salaries/), accessed February 8, 2013.

Khazan, Olga
2012 Where It's Most Dangerous to Be an Aid Worker. *WorldViews*.
[http://www.washingtonpost.com/blogs/worldviews/wp/2012/12/26/heres-where-its-most-
dangerous-to-be-an-aid-worker/](http://www.washingtonpost.com/blogs/worldviews/wp/2012/12/26/heres-where-its-most-dangerous-to-be-an-aid-worker/), accessed February 5, 2013.

LHWs Stage Sit-in Protest
2011 *The Nation*, March 24. [http://nation.com.pk/pakistan-news-newspaper-daily-
english-online/Regional/Karachi/24-Mar-2011/LHWs-stage-sitin-protest](http://nation.com.pk/pakistan-news-newspaper-daily-english-online/Regional/Karachi/24-Mar-2011/LHWs-stage-sitin-protest), accessed June
26, 2011.

LHWs Strike a Deal with Govt, End Protest
2014 *Dawn*, February 19. <http://www.dawn.com/news/1088001>, accessed October 16,
2014.

McCoy, David, Sara Bennett, Sophie Witter, et al.

2008 Salaries and Incomes of Health Workers in Sub-Saharan Africa. *The Lancet* 371(9613): 675–681.

Moazzam, Farah

2011 Health Risks: Lady Health Workers Demand Proper Wages and Recognition in Return for Their Services to Build a Healthy Society. *The News*, May.

<http://jang.com.pk/thenews/may2011-weekly/nos-29-05-2011/dia.htm>, accessed June 26, 2011.

Moodie, T. Dunbar

1986 The Moral Economy of the Black Miners' Strike of 1946. *Journal of Southern African Studies* 13(1): 1–35.

Morgan, Lynn M.

1993 *Community Participation in Health: The Politics of Primary Care in Costa Rica*. Cambridge University Press.

Nkonki, Lungiswa, Julie Cliff, and David Sanders

2011 Lay Health Worker Attrition: Important but Often Ignored. *Bulletin of the World Health Organization* 89(12): 919–923.

Polio Vaccination Workers Shot Dead in Pakistan

2012 *The Guardian*, December 18.

<http://www.guardian.co.uk/world/2012/dec/18/polio-vaccination-workers-shot-pakistan>, accessed March 15, 2013.

Rowe, Alexander, Don de Savigny, Claudio Lanaza, and CG Victora

2005 How Can We Achieve and Maintain High-Quality Performance of Health Workers in Low-Resource Settings? *Lancet* 366(9490): 1026.

Scott, James C.

1977 *The Moral Economy of the Peasant: Rebellion and Subsistence in Southeast Asia*. Yale University Press.

1985 *Weapons of the Weak*. New Haven: Yale University Press.

1990 *Domination and the Arts of Resistance*. New Haven: Yale University Press.

Shamsi, Waseem

2011 Health Workers Block Highway, March 24.

<http://www.dawn.com/2011/03/24/health-workers-block-highway.html>, accessed June 26, 2011.

Shoe-String Budget: Health Worker Fuel Compensation Cut in Half to 35 Litres
2011 The Express Tribune, May 24. <http://tribune.com.pk/story/174526/shoe-string-budget-health-worker-fuel-compensation-cut-in-half-to-35-litres/>, accessed June 26, 2011.

Taksa, Lucy

1991 "Defence Not Defiance": Social Protest and the NSW General Strike of 1917. *Labour History*(60): 16.

Thompson, E. P.

1971 The Moral Economy of the English Crowd in the Eighteenth Century. *Past & Present*(50): 76–136.

UNICEF, and World Health Organization

2012 UNICEF and WHO: Polio Vaccinators Attacked in Pakistan Are "Heroes."
UNICEF USA. <http://www.unicefusa.org/press/releases/unicef-and-who-polio-vaccinators-attacked-pakistan-are-%E2%80%9Cheroes%E2%80%9D/8190>, accessed August 15, 2014.

Walsh, Declan, and Donald G McNeil

2012 Female Vaccination Workers, Essential in Pakistan, Become Prey. *The New York Times*, December 20. <http://www.nytimes.com/2012/12/21/world/asia/un-halts-vaccine-work-in-pakistan-after-more-killings.html>, accessed February 5, 2013.

Wasif, Sehrish

2012 Polio Campaign: Distressed with Security and Monetary Concerns, LHWs Camp Outside PM Secretariat. *The Express Tribune*, December 23. <http://tribune.com.pk/story/483148/polio-campaign-distressed-with-security-and-monetary-concerns-lhws-camp-outside-pm-secretariat/>, accessed February 11, 2013.

WHO Regional Office for the Eastern Mediterranean

2014 Summary Report on the Technical Advisory Group Meeting on Polio Eradication for Pakistan. Islamabad: WHO.

World Health Organization

2014 Global Polio Eradication Initiative Financial Resource Requirements 2013-2018 As of 1 February 2014. Geneva: WHO.

